DCF-3019
05/2015 (Rev.)

Careline Intake
Voluntary Services Initial Request

Date:

Time:

Mother:
DOB:
Ethnicity:
Primary Language:
Address:
Telephone:
Home:
Work:
Cell:
Does this parent reside in the home with the child? Yes ☐ No ☐

Father:
DOB:
Ethnicity:
Primary Language:
Address:
Telephone:
Home:
Work:
Cell:
Does this parent reside in the home with the child? Yes ☐ No ☐

Legal Guardian(s)/Name(s):
DOB(s):
Ethnicity(ethnicities):
Primary Language(s):
Address:
Telephone:
Home:
Work:
Cell:

Prior DCF History:

LINK/CMS# and date closed: LINK# Closed:
CMS# Closed:

Child's name for whom Voluntary Services are being sought:
DOB:
Ethnicity:
Primary Language:

Check here if caller is child age 14 years or older: ☐

Referral Source:

Is child adopted: Y ☐ N ☐
Private Adoption ☐ DCF Adoption ☐ Receiving DCF Subsidy? Yes ☐ No ☐
Out of State Adoption/ICPC Yes ☐ No☐
Present school: Grade:
Special education: Yes ☐ No ☐

Child's Health Insurance:
Insurance Co:
Insurance ID#:
Husky Insurance Number (if applicable):

Has the child been denied coverage by the insurance company? Yes ☐ No ☐
If yes, for what services?

Was the Office of the Health Care Advocate (OHA) information provided to the parent(s)? Yes ☐ No ☐
Did parent(s) provide verbal consent to release contact info to OHA? Yes ☐ No ☐
OHA's Toll Free Number: (866) 466-4446

Has the child been made eligible for DDS? Yes ☐ No ☐
If yes: Case Manager's Name, if applicable:
Phone Number:
DDS Client #:

Sibling(s) in the home, DOB(s), ethnicity(ies), and primary language(s):

Other household members, DOB(s), relationship(s), ethnicity(ies), and primary language(s):

Is anyone in the home deaf or hearing impaired? Yes ☐ No ☐

Interpreter Needed? Yes ☐ No ☐

Child's Psychiatrist:
Address:
Phone number:

Child's Clinician:
Address:
Phone number:

Child's Current Diagnosis (DSM V):

Child's current medications (name/dosage):

Child's history of hospitalizations (hospital name/date):

Present services in place:

Delinquency case, FWSN case, probation:
Yes ☐ No ☐

Name of Probation Officer/Court, if applicable:

Reason Requesting Voluntary Services:

(In narrative format please describe the reason(s) for requesting Voluntary Services and provide available information pertaining to any behaviors checked "yes" below)

Behavioral/Medical History (Child): (If yes, please explain.)

A.	Self-mutilation:	Yes ☐ No ☐
B.	School avoidance/Truancy:	Yes ☐ No ☐
C.	Depression:	Yes ☐ No ☐
D.	Suicidal behaviors:	Yes ☐ No ☐
E.	Assaultive behaviors:	Yes ☐ No ☐
F.	Threatening behaviors:	Yes ☐ No ☐
G.	Damage to property (own/others):	Yes ☐ No ☐
H.	History or use of substances:	Yes ☐ No ☐
I.	Runaway behaviors	Yes ☐ No ☐
J.	Fears/Anxiety(not age-appropriate):	Yes ☐ No ☐
K.	Night terrors:	Yes ☐ No ☐
L.	Bed wetting:	Yes ☐ No ☐
M.	Soiling:	Yes ☐ No ☐
N.	Sexually reactive or offending:	Yes ☐ No ☐
O.	Fire-setting behaviors:	Yes ☐ No ☐
P.	Hurts animals:	Yes ☐ No ☐
Q.	Developmentally delayed:(IQ<70)	Yes ☐ No ☐
R.	Significant medical problems:	Yes ☐ No ☐
S.	Hearing impaired:	Yes ☐ No ☐
T.	Vision impaired:	Yes ☐ No ☐
U.	Physically disabled:	Yes ☐ No ☐
V.	Brain injury:	Yes ☐ No ☐
W.	Pregnant:	Yes ☐ No ☐

Behavioral/Medical History (Family): (If yes, please explain.)

A. Domestic violence (witnessed by child):	Yes ☐	No ☐
B. Physical abuse (child):	Yes ☐	No ☐
C. Incarceration of parent:	Yes ☐	No ☐
D. Substance abuse of parent:	Yes ☐	No ☐
E. Death of a parent:	Yes ☐	No ☐
F. Mental health (parent):	Yes ☐	No ☐
G. Significant medical problems:	Yes ☐	No ☐

CLSW:

CLPM: